

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10692** **CERTIFICATE OF DEATH**

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				d. STREET ADDRESS <b>745 Guilford Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES COCHRAN</b> Middle <b>ANNAN</b> Last				4. DATE OF DEATH Month <b>Oct</b> Day <b>13</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19 1897</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator Reichards Garage</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Emmitsburg Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Stewart Annan</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Morrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-1954</b>		17. INFORMANT Address <b>Mrs Alice Newcomer Annan Hagerstown Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>Hypertension C. V. Disease</b> (c) <b>Coronary Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 1955</b> , to <b>Oct 13 1956</b> , that I last saw the deceased alive on <b>Oct 13 1956</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert V. L. Campbell</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>10/15/56</b>			
PHYSICIAN'S NAME (Type) <b>Robert V. L. Campbell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-15-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md</b>				24a. REC'D BY REGISTRAR <b>Oct 17 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Rowers</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		Male		45		White		1912		Baltimore, Md.		1956		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. PREVIOUS ILLNESS		14. OCCUPATION		15. EDUCATION		16. RELIGION		17. MARITAL STATUS		18. SOCIAL STATUS		19. ALCOHOLIC DRINKING		20. TOBACCO SMOKING		21. OTHER HABITS		22. OTHER FACTS		23. OTHER FACTS		24. OTHER FACTS	
None		None		None		None		None		None		None		None		None		None		None		None	
25. SIGNATURE OF PHYSICIAN		26. SIGNATURE OF REGISTRAR		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR		31. SIGNATURE OF PHYSICIAN		32. SIGNATURE OF REGISTRAR		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. R.

OCT 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

10694

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>9 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Route # 4</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NANCY JEAN BLACK</b>			4. DATE OF DEATH Month Day Year <b>Oct. 16 1956</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1955</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Kenneth L. Black</b>				14. MOTHER'S MAIDEN NAME <b>Sherley Ann Statler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Kenneth L. Black R#4 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia bilateral</b> <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastro Enteritis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>76 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>15 Oct</b> , 19 <b>56</b> , to <b>16 Oct</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>16 Oct</b> , 19 <b>56</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eldon G. Hoachlander</b> M.D.						ADDRESS (Street, city or town, state) DATE SIGNED <b>10/16/56</b>	
PHYSICIAN'S NAME (Type) <b>ELDON G. HOACHLANDER M.D. 115 W. Washington St. Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 18, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Oct. 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. A. Host U.S.</b>	





10694

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Frederick Bryan</u>				4. DATE OF DEATH Month Day Year <u>October 27, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 11, 1912</u>	
9. AGE (In years last birthday) <u>44 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. Rubber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-9903</u>		17. INFORMANT Address <u>Mrs. Katherine Bryan Marlowe, West Vir.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aneurysm of Circle of Willis</u> DUE TO (b) <u>Hypertensive cardio-vascular renal disease</u> DUE TO (c) <u>442x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 years?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm of the thoracic aorta</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 19</u> , 19 <u>53</u> to <u>Oct 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 27</u> , 19 <u>56</u> , and that death occurred at <u>1:02 am</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Archie Robert Cohen, M.D. Clear Spring, Md. 10/27/56</u>							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D. Clear Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct. 30, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 2420

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BUREAU V. S.

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonesboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS <b>414 Brunswick</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Mauden</b> Last <b>Caniford</b>		4. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-21-1900</b>
9. AGE (In years last birthday) yrs. <b>55</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Gill Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Lee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Jack F. Caniford</b>		Address <b>Brunswick, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Haemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 10, 1956</b> to <b>Oct 19, 1956</b> , that I last saw the deceased alive on <b>October 17, 1956</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. W. Lukan</b>		ADDRESS (Street, city or town, state) <b>Brunswick</b>	
PHYSICIAN'S NAME (Type) <b>G. W. Lukan M.D.</b>		DATE SIGNED <b>Oct 20, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-21-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>	22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feste</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>OCT 30 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Barts</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

100-100000

NAME OF DECEASED JAMES H. HILL		DATE OF BIRTH 10-10-1900		PLACE OF BIRTH St. Louis, Mo.	
SEX Male		RACE White		EDUCATION High School	
OCCUPATION None		MARRIAGE None		RELIGION None	
DATE OF DEATH 10-10-1956		PLACE OF DEATH St. Louis, Mo.		CAUSE OF DEATH None	
MANNER OF DEATH None		DISEASE OR INJURY None		TREATMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None	
SIGNATURE OF CLERK None		SIGNATURE OF REGISTRAR None		SIGNATURE OF JUDGE None	

BUREAU V. 5

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10695

## CERTIFICATE OF DEATH

10697

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 mins.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1924 1/2 Gay Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>CASTIE</u>				4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 22, 1956</u>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Edward L. Castle</u>			
14. MOTHER'S MAIDEN NAME <u>Frances J. Mills</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT Name <u>Edward L. Castle</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital deformities incompatable</u> <u>759.3</u> DUE TO <u>with life.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>56</u> , to <u>Oct 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 21</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10/22/56</u> DATE SIGNED ACTUAL SIGNATURE <u>F. D. Dove Jr.</u> M.D. <u>214 N. Potomac St. Hagerstown, Md.</u>							
PHYSICIAN'S NAME (Type) <u>F. D. Dove, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Hamilton Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 24 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>							

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## SALLY.

OCET 103



218

BUREAU V. S.

OCT 26 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

205

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Boonsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>	
c. LENGTH OF STAY IN 1b <u>8 mo.</u>		d. STREET ADDRESS <u>10 X - 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kelly - Fahreny Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDITH LENOIRA CLEM</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Dudrow</u>		14. MOTHER'S MAIDEN NAME <u>Mary Postian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20 3786</u>	
17. INFORMANT <u>Mrs. Ross Clem</u>		Address <u>613 Biggs Ave., Fred.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.2</u> DUE TO <u>acute angina</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> (c) <u>Paralytic agitation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1, 1956</u> to <u>Oct 14, 1956</u> , that I last saw the deceased alive on <u>October 14, 1956</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Lilien</u> M.D.		ADDRESS (Street, city or town, state) <u>Boonsboro</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Lilien M.D.</u>		DATE SIGNED <u>10/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 17 Oct. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

OCT 18 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

300

10748

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg R # 2</b> c. LENGTH OF STAY IN 1b <b>9 Mos</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cavetown</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg R # 2</b> d. STREET ADDRESS <b>Cavetown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAE TERESA CLINE</b>				4. DATE OF DEATH Month Day Year <b>Oct 10 1956 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 22 1884</b> 9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Foxville Fred Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ephram Hauver</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ellen Gordon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>John W. Cline Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis Heart</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 mts</b> <b>20 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 2 1940</b> to <b>Oct 10 1956</b> , that I last saw the deceased alive on <b>Oct 10 1956</b> and that death occurred at <b>11 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>944 Kohler M.D. Smithsburg Md 10/11/56</b>							
ACTUAL PHYSICIAN'S NAME (Type) <b>944 Kohler</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>15 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>R. H. Z...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OFFICIAL			
						</																																			



10696

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>7 S. Artizan Street</b>							
3. NAME OF DECEASED (Type or print) <b>Oliver Thomas Coakley</b>		4. DATE OF DEATH Month <b>10</b> Day <b>11</b> Year <b>1956</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1876</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer &amp; Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Byron Tannery</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip P. Coakley</b>				14. MOTHER'S MAIDEN NAME <b>Ellen C. Carrier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-7319</b>		17. INFORMANT <b>Miss Helen Coakley</b> Address <b>Williamsport Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis, perforation</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 Oct</b> , 19 <b>56</b> , to <b>11 Oct</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10 Oct</b> , 19 <b>56</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Haak</b>				ADDRESS (Street, city or town, state) <b>28 W. Potomac St. Williamsport, Md.</b>			
PHYSICIAN'S NAME (Type) <b>PAUL HAAK, M.D.</b>				DATE SIGNED <b>12 Oct 56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard &amp; June Hansen</b>				ADDRESS <b>Williamsport Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 16, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

OCT 18 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE**  
**10697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>3 Yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>27 So Locust St</b>				d. STREET ADDRESS <b>27 So Locust St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALBERT ROSS COLLIFLOWER</b>				4. DATE OF DEATH Month Day Year <b>Oct 23 1956 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 1 1890 65</b>	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eyerlys Inc.</b>		11. BIRTHPLACE (State or foreign country) <b>Graceham Fred Co Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Elmer E. Colliflower</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Willhide</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-3996</b>		17. INFORMANT <b>Mrs Esther L. Colliflower</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>acute coronary occulsion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				27 So Locust St Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <b>none</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/26/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Oct 26 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Phasht Bowser</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH - BUREAU OF  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		SIGNATURE OF EXAMINER [Illegible]	
TITLE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
ADDRESS OF DECEASED [Illegible]		ADDRESS OF EXAMINER [Illegible]	
CITY [Illegible]		COUNTY [Illegible]	
STATE [Illegible]		ZIP CODE [Illegible]	

BUREAU V. 1

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10702

10749

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>63 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		d. STREET ADDRESS <b>RFD #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD #2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Richard</b> Last <b>Crowther</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1876</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>orchardist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>peach orchard</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David W. Crowther</b>		14. MOTHER'S MAIDEN NAME <b>Catharine H. Brundage</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>G. Rodney Crowther, Leitersburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic Mellitus</b> DUE TO (c) <b>Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8:45 P.M.</b> <b>42 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 31, 1956</b> to <b>Oct 31, 1956</b> that I last saw the deceased alive on <b>Oct 31, 1956</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg Md</b> DATE SIGNED <b>10/31/56</b>			
ACTUAL SIGNATURE <b>G. A. Kehler</b> M.D.		DATE SIGNED <b>10/31/56</b>	
PHYSICIAN'S NAME (Type) <b>G. A. Kehler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-3-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '56</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

NAME OF DECEASED William H. Crowder		SEX Male		AGE 57 Years		DATE OF BIRTH Nov. 27, 1882	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
NAME OF NEXT OF KIN David W. Crowder		NAME OF PHYSICIAN Dr. J. H. Crowder		NAME OF BURIAL PLACE St. Paul's Church		DATE OF BURIAL Dec. 1, 1939	
NAME OF DECEASED William H. Crowder		SEX Male		AGE 57 Years		DATE OF BIRTH Nov. 27, 1882	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
NAME OF NEXT OF KIN David W. Crowder		NAME OF PHYSICIAN Dr. J. H. Crowder		NAME OF BURIAL PLACE St. Paul's Church		DATE OF BURIAL Dec. 1, 1939	

BUREAU A. S.

1056

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 2 FilmG205 10-22-56 et  
**CERTIFICATE OF DEATH**

10703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Unknown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>133 Blooms Alley</b> <b>Washington County Home</b>			
3. NAME OF DECEASED (Type or print) First <b>Alta</b> Middle <b>Scott</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-76</b>		9. AGE (In years last birthday) <b>8D</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Wash. County Home Hag. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lung</b> DUE TO (c) <b>Arteriosclerotic Heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>  <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16, 1956</b> to <b>October 3, 1956</b> , that I last saw the deceased alive on <b>October 3, 1956</b> , and that death occurred at <b>3:50 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b> <b>Clear Spring, Maryland</b> <b>October 4, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Unknown</b>		<b>10-4-56</b>		<b>Clear Spring, Md.</b>		<b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 15 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. A. Brown</b>			

MASTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

OCT 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10699 Dr Earl young  
CERTIFICATE OF DEATH

10704  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. county Hospital</b>				d. STREET ADDRESS <b>101 So Potomac St.</b>			
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>ELIZABETH</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 11 1874</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Keedtsville Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas Norris</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lapole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs Viola M. Burger</b>				Address <b>445 Frederick St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO (c) <b>8 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11.26.49</b> , 19____, to <b>10.21.56</b> , 19____, that I last saw the deceased alive on <b>10.21.56</b> , 19____, and that death occurred at <b>7.00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 N. Potomac St., Hagerstown, Md.</b> DATE SIGNED <b>10.22.56</b> ACTUAL SIGNATURE <b>Dr Earl Young</b> PHYSICIAN'S NAME (Type) <b>S. Earl Young M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Oct. 24. 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas H. Powers</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED ANDREW E. GOTTEN		2. SEX Male		3. AGE 40	
4. DATE OF DEATH OCT 26 1955		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. DATE OF MARRIAGE 1915		15. NAME OF SPOUSE Mary E. Gottén	
16. NAME OF FATHER John E. Gottén		17. NAME OF MOTHER Mary E. Gottén		18. NAME OF BIRTHPLACE Baltimore, Md.	
19. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		20. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		21. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
22. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		23. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		24. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
25. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		26. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		27. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
28. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		29. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		30. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
31. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		32. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		33. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
34. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		35. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		36. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
37. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		38. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		39. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
40. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		41. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		42. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
43. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		44. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		45. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
46. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		47. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		48. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
49. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		50. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		51. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
52. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		53. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		54. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
55. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		56. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		57. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
58. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		59. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		60. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
61. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		62. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		63. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
64. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		65. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		66. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
67. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		68. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		69. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
70. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		71. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		72. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
73. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		74. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		75. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
76. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		77. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		78. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
79. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		80. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		81. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
82. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		83. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		84. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
85. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		86. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		87. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
88. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		89. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		90. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
91. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		92. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		93. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
94. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		95. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		96. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
97. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		98. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		99. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
100. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		101. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		102. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	

RECEIVED

OCT 26 1955

BUREAU V. S.



10750

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN 1b <u>10 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>		d. STREET ADDRESS <u>15 NOXVILLE RD. R.I.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>DAYHOFF</u>		4. DATE OF DEATH Month <u>OCTOBER</u> - Day <u>22</u> - Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 27, 1870</u>
9. AGE (In years last birthday) <u>86-0-25</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ROCKERSVILLE WASH. CO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH DEENER</u>		14. MOTHER'S MAIDEN NAME <u>ANN REBECCA STINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LEE DEENER</u>		Address <u>BOONSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.2</u> DUE TO <u>Acute angina</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> (c) <u>with hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10, 1956</u> , to <u>Oct. 22, 1956</u> , that I last saw the deceased alive on <u>October 22, 1956</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. He Van</u>		ADDRESS (Street, city or town, state) <u>Boonsboro</u>	
PHYSICIAN'S NAME (Type) <u>G. W. He Van</u>		DATE SIGNED <u>10/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 25, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF BROTHERS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BROWNVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>John C. Ball</u>	

OCT 29 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10700

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10706

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>60 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>208 Willard St.</u>				d. STREET ADDRESS <u>208 Willard St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Alexander</u> Last <u>Delosier</u>				4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 29, 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fair Board</u>		11. BIRTHPLACE (State or foreign country) <u>Smithsburg - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John J. Delosier</u>				14. MOTHER'S MAIDEN NAME <u>Minerva Densmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>214-09-0315</u>		17. INFORMANT <u>Mrs. Opal Delosier</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>acute cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6hrs</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>none</u> p. m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-29-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 31- 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 2, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles H. Brower</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 5 10

1 Item 20  
File G206,  
11-15-56 ans

Continued Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Wash. C. D. M.E. 11-1-56  
10707  
10707  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>	
c. LENGTH OF STAY IN 1b <u>2 Days</u>		d. STREET ADDRESS <u>431 E. Balto. ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>C.</u> Middle <u>DETTRICH</u> Last		4. DATE OF DEATH <u>OCT. 27</u> Month <u>27</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Greencastle, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse M. Stine</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Unger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Earl Stine</u> Address <u>Baltimore 19, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide poisoning</u> <u>890.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Source: furnace</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient apparently exposed to high concentration of carbon monoxide for at least 10 hours, possibly 15 hours, and discovered in uncon-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>10-23-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Greencastle</u> (County) <u>Franklin</u> (State) <u>Penna</u>	
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>39</u> , to <u>10/27</u> , 19 <u>56</u> that I last saw the deceased alive on <u>10/26</u> , 19 <u>56</u> , and that death occurred at <u>5:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>McBreen</u> M.D. <u>Greencastle, Pa.</u>		DATE SIGNED <u>10/28/56</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Brown, M.D.</u>		<u>Greencastle, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Munnich</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>Nov. 2, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. C. Bowers</u>



# CERTIFICATE OF DEATH

BUREAU V. S.

NOV 5 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10708

302

10751

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAUGANSVILLE</b>			c. LENGTH OF STAY IN 1b <b>4 YRS.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MENNONITE HOME</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CHRISTIAN</b> Middle <b>R.</b> Last <b>EBY</b>			4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>6</b> Year <b>19 56</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/1881</b>		9. AGE (In years last birthday) <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>CLAM EBY</b>		
14. MOTHER'S MAIDEN NAME <b>ELIZABETH RIFE</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>MRS EARL SHANK</b> Address <b>RT.#3 HAGERSTOWN MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral hernia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>Year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>52</b> , to <b>6 Oct</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3 Oct</b> , 19 <b>56</b> , and that death occurred at <b>6<sup>45</sup> A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>10/7/56</b>					
ACTUAL SIGNATURE <b>Edwin S. Boudland</b> M.D.					
PHYSICIAN'S NAME (Type) <b>E. H. S. Hagerstown Md.</b>					
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/8/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>REIFF CHURCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR <b>Oct. 8, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. OCCUPATION [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MANNER OF DEATH [REDACTED]</p>		<p>10. MEDICAL HISTORY [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>17. SIGNATURE OF DECEASED [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>21. SIGNATURE OF DECEASED [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>23. SIGNATURE OF DECEASED [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>27. SIGNATURE OF DECEASED [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>29. SIGNATURE OF DECEASED [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>33. SIGNATURE OF DECEASED [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>35. SIGNATURE OF DECEASED [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>39. SIGNATURE OF DECEASED [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>41. SIGNATURE OF DECEASED [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>45. SIGNATURE OF DECEASED [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>47. SIGNATURE OF DECEASED [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>51. SIGNATURE OF DECEASED [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>53. SIGNATURE OF DECEASED [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>	
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<p>59. SIGNATURE OF DECEASED [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
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<p>63. SIGNATURE OF DECEASED [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>65. SIGNATURE OF DECEASED [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>69. SIGNATURE OF DECEASED [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>71. SIGNATURE OF DECEASED [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>75. SIGNATURE OF DECEASED [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>77. SIGNATURE OF DECEASED [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>81. SIGNATURE OF DECEASED [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>83. SIGNATURE OF DECEASED [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
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<p>87. SIGNATURE OF DECEASED [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>89. SIGNATURE OF DECEASED [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>93. SIGNATURE OF DECEASED [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>95. SIGNATURE OF DECEASED [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>99. SIGNATURE OF DECEASED [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS [REDACTED]</p>	

RECEIVED  
OCT 10 1956  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10709

10752

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wawh.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #2		d. STREET ADDRESS RFD #2	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Helena Flegel		4. DATE OF DEATH Month Day Year Oct. 3, 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1894
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Emmitsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Long		14. MOTHER'S MAIDEN NAME Annie Grottle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Marvin Dietrich, Maugansville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelogenous Leukemia</u> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH June 1-1956	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from June 1, 1956, to Oct. 3, 1956, that I last saw the deceased alive on Oct 3, 1956, and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 16-4-56 ACTUAL SIGNATURE Sidney Novenstein M.D. F.R.C.S. (Lond.) PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN 22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 10-6-56 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 22d. LOCATION (City, town, or county) (State) Hagerstown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct 8, 1956 24b. REGISTRAR'S SIGNATURE B. H. Bowers	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

## CERTIFICATE OF DEATH

Dr Binford

10710

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. county hospital</b>		e. STREET ADDRESS <b>31 So Prospect St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GERTRUDE LAVINIA GEORGE</b>		4. DATE OF DEATH Month Day Year <b>Oct 19 1956 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 19 1873</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Wash. Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob C. Grove</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mumma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Frances Mumma</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myelogenous Leukemia</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 October 1956</b> , to <b>19 October 1956</b> , that I last saw the deceased alive on <b>19 October 1956</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard T. Binford</b> M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>	
DATE SIGNED <b>21 Oct 56</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D. 1135 POTOMAC AVE., HAGERSTOWN, MARYLAND 21 OCT. 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-23-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Linwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Haverhill Essex Co Mass</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct. 22, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis C. Cowers</b>	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
JAMES H. BROWN		45		Male		White		1956		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		Teacher		High School		Married		None	
Date of Birth		Date of Death		Date of Burial		Place of Burial		Signature of Physician		Signature of Registrar	
1911		1956		1956		Baltimore, Md.		[Signature]		[Signature]	

BUREAU V. 3

OCT 24 1956

RECEIVED

ANDREW K. GALT, Registrar  
 BIRTH 12-25-22, BALTIMORE, MARYLAND  
 RICHARD J. DIERKS, Director, 1125 FOLLY AVENUE, BALTIMORE 21

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells

Reg. Dist. No.

10711

303

10753

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring R # 3</u>		c. LENGTH OF STAY IN 1b <u>7 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring R #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>near Hanging Rock</u>				d. STREET ADDRESS <u>near Hanging Rock</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD STOUFFER HAGER</u>				4. DATE OF DEATH Month Day Year <u>October 8 1956 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 29 1904 51 yrs.</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Old Forge Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Harry Hager</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude V. Stouffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-8518</u>		17. INFORMANT <u>George Harry Hager Clear Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial avulsion of skull and brain tissue</u> DUE TO <u>due to shotgun wound (16 gauge)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shotgun (16 gauge)</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> p. m. <u>Oct. 8 19 56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>on farm</u>		20f. (City or town) (County) (State) <u>R# 2 Clearspring Wash Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Murray</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

## CERTIFICATE OF DEATH

Reg. Dist. No.

10712  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>HALE</b> Last <b>HALE</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Francis Hale</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-8992</b>	
17. INFORMANT <b>Mrs. Lillian E. Everhart</b>		104 Address <b>Rowe St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac decompensation</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Terminal pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>3-4 m.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Oct 18</b> , 19 <b>56</b> , to <b>Oct. 21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 21</b> , 19 <b>56</b> , and that death occurred at <b>9:15</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>10/23/56</b>			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b> <b>217 W. Washington St., Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 25, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>			
24a. REC'D BY REGISTRAR <b>Oct 25 1956</b>			
24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			



CERTIFICATE OF DEATH

See Note on

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		Natural		Heart Disease		Jan 15, 1956		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Usual Residence		Usual Address		Usual Telephone		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor		Usual Pharmacist		Usual Dentist		Usual Funeral Home	
Teacher		Married		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.		1234 Main St.	
Education		Religion		Race		Color		Height		Weight		Blood Type		Habit		Diet		Exercise		Stress		Mental State	
High School		Catholic		White		White		5'10"		170 lbs		O+		None		Regular		Daily		None		Normal	
Family History		Social History		Medical History		Surgical History		Dental History		Pharmaceutical History		Psychiatric History		Neurological History		Ophthalmological History		Otolaryngological History		Cardiovascular History		Respiratory History	
None		None		None		None		None		None		None		None		None		None		None		None	
Autopsy		Burial		Cremation		Interment		Disposition of Remains		Disposition of Organs		Disposition of Tissues		Disposition of Bones		Disposition of Teeth		Disposition of Hair		Disposition of Nails		Disposition of Skin	
No		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No		Yes	
Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 10704 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10713

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAGERSTOWN</u>	c. LENGTH OF STAY IN 1b <u>6 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CLEARSPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSP.</u>		d. STREET ADDRESS <u>R. #1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LESTER R</u> Middle <u>Hawbaker</u> Last <u>Hawbaker</u>		4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. FARMING</u>	9. AGE (In years lost birthday) <u>45</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>MERCERSBURG, PA. R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL N. HAWBAKER</u>		14. MOTHER'S MAIDEN NAME <u>JARAH HAWBAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-9357</u>	17. INFORMANT <u>Preston Hawbaker</u> Address <u>Mercersburg, Pa.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infective Endocarditis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Valvular Disease</u> DUE TO (c) <u>15 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 25, 1956</u> to <u>Oct 10, 1956</u> that I last saw the deceased alive on <u>Oct 9, 1956</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>19/10/56</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WELSH RUN BRETHERN</u>	22d. LOCATION (City, town, or county) (State) <u>FRANKLIN Co. MERCERSBURG, PA. R.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Zimmer</u> ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR <u>Oct 12, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Bowers</u>

BUREAU V. S.

OCT 15 1956

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10705 CERTIFICATE OF DEATH

10714

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Washington</i>		MARYLAND		STATE <i>Penna.</i>		COUNTY <i>Franklin</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hagerstown</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Lemasters, Pa. 75X-3</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Wash. Co. Hosp.</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>MARY C. HECKMAN</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Oct. 15, 1956</i>			
<b>5. SEX</b> <i>FEM.</i>	<b>6. COLOR OR RACE</b> <i>WHITE</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Widow</i>	<b>8. DATE OF BIRTH</b> <i>Nov. 27, 1865</i>		<b>9. AGE last birthday</b> <i>90</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>St. Thomas, Pa. R.I.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Isaac Etter</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Annie Phiel</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>None</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Anne Mary Heckman, Lemasters, Pa.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>416X IMMEDIATE CAUSE (A)</b> <i>Chronic Rheumatic Heart Disease</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>80 yrs.</i>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>9/1</i>....., 19<i>29</i>....., to <i>10/15</i>....., 19<i>56</i>....., that I last saw the deceased alive on <i>10/15</i>....., 19<i>56</i>....., and that death occurred at <i>12:45</i> P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. B. Brown, M.D.</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Shenandoah, Pa.</i>		<b>DATE SIGNED</b> <i>10/16/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>10/18/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>St. Thomas Cem.</i>		<b>LOCATION (City, town, or county) (State)</b> <i>St. Thomas, Pa.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>Oct. 16, 1956</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Charles H. Powers</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>F. H. Lingen</i>		<b>ADDRESS</b> <i>Mercersburg, Pa.</i>	

# CERTIFICATE OF DEATH

Form 100-104

A. DEATH INFORMATION OF DECEASED

B. CAUSE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		HOSPITAL		PHYSICIAN	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		SEX	
DISEASE OR INJURY		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		HOSPITAL		PHYSICIAN	

PHOTOGRAPH

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness or who has attended the deceased at the time of death. It is to be filled out in the case of a death occurring in a hospital, institution, or other place where the deceased was under the care of a physician or other qualified person. It is to be filled out in the case of a death occurring at home, or in a place where the deceased was not under the care of a physician or other qualified person, by the physician or other qualified person who has attended the deceased during his last illness or who has attended the deceased at the time of death. It is to be filled out in the case of a death occurring in a hospital, institution, or other place where the deceased was under the care of a physician or other qualified person, by the physician or other qualified person who has attended the deceased during his last illness or who has attended the deceased at the time of death. It is to be filled out in the case of a death occurring at home, or in a place where the deceased was not under the care of a physician or other qualified person, by the physician or other qualified person who has attended the deceased during his last illness or who has attended the deceased at the time of death.

**RECEIVED**  
OCT 18 1956  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10706

## CERTIFICATE OF DEATH

Dr Hocklender

10715

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>P. Va.</u> b. COUNTY <u>Hampshire</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagers town</u>				c. LENGTH OF STAY IN 1b <u>7 Mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Monor Nursing Home</u>				d. STREET ADDRESS <u>Romney</u>			
3. NAME OF DECEASED (Type or print) First <u>BRUCE</u> Middle <u>MONROE</u> Last <u>HELM</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 7 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>85</u> Days <u>x</u>	IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tres Box Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Helm</u>				14. MOTHER'S MAIDEN NAME <u>Annie Reecher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Carleton Helm Hagerstown Md. R # 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1.5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May</u> 19 <u>56</u> , to <u>Oct</u> 19 <u>56</u> , that I last saw the deceased alive on <u>15 Oct</u> 19 <u>56</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Eldon D Hocklender M.D.</u>				<u>1156 Washington</u> <u>10/16/56</u>			
PHYSICIAN'S NAME (Type) <u>Eldon D Hocklender</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hager town Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffin</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>Oct. 18. 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
STREET ADDRESS		CITY	
STATE		COUNTY	
ZIP CODE		HOSPITAL	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	

BUREAU V. S.

OCT 22 1956

RECEIVED

ANDREW W. COLLINS, REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10707

CERTIFICATE OF DEATH

10716

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>Big Spring RFD #1</b>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Dailey</b> Last <b>Henson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 11, 1885</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Dam # 4 Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Henson</b>				14. MOTHER'S MAIDEN NAME <b>Annie R. Fowler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Cora Eva Henson</b> Address <b>Big Spring RFD #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Sept. 7, 1955</b> to <b>Oct. 24, 1956</b> , that I last saw the deceased alive on <b>October 24, 1956</b> , and that death occurred at <b>7:20 pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b> <b>Clear Spring, Md.</b> <b>10/26/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>October 28, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pinesburg Mennonite</b>		22d. LOCATION (City, town, or county) (State) <b>Pinesburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leg Williams</b>				24a. REC'D BY REGISTRAR <b>Oct. 27, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blush Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 51

1956 0815

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10717

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>30 N. Walnut St.,</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>30 N. Walnut St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Franklin</b> Last <b>Hilliard</b>				4. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1891</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Md. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>Clark County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Hilliard</b>				14. MOTHER'S MAIDEN NAME <b>Fanny Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>705-12-2083</b>		17. INFORMANT <b>Mrs. Esther Hilliard</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Bronchial pneumonia</b> DUE TO (b) <b>491X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>322.2</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>alcoholism</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>-- -- --</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>10-16-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-17-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Det. 18. 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



OCT 22 1956

BUREAU V. S.

10799

## CERTIFICATE OF DEATH

Rd E.W.Ditto 111

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>17 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
e. STREET ADDRESS <b>Chewsville</b>							
3. NAME OF DECEASED (Type or print) First <b>ELVIN</b> Middle <b>RAY</b> Last <b>HOOVER</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9 1882</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer- Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Chewsville Wash. Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Levi Hoover</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Easterday</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Katie E. Hoover</b> Address <b>Smithsburg R #2 Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-vascular disease</b> DUE TO (c) <b>chronic</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Prostatic Hypertrophy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 13, 1956</b> , to <b>Oct 20, 1956</b> , that I last saw the deceased alive on <b>Oct 19, 1956</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D. <b>217 W. Washington St.</b>				<b>10/22/56</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D., 217 W. Washington St., Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-23-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mausoleum Smithsburg</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> Address <b>Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Oct. 24. 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10719**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>59 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>339 Jefferson St.</b>				d. STREET ADDRESS <b>339 Jefferson St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Max</b> First <b>McPherson</b> Middle <b>Hose</b> Last				4. DATE OF DEATH <b>Oct.</b> Month <b>21</b> Day Year <b>56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1896</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store- Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H. Hose</b>				14. MOTHER'S MAIDEN NAME <b>Margaret E. Baughman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-32-5160</b>		17. INFORMANT Address <b>Miss Mary Hose Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease with</b> <b>443X</b> DUE TO <b>congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , to <b>Oct. 21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 21</b> , 19 <b>56</b> , and that death occurred at <b>8:30 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St., Hagerstown, Maryland</b> DATE SIGNED <b>10/22/56</b> ACTUAL SIGNATURE <b>B. B. Kneisley</b> M.D. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b> <b>Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-24-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				24a. REC'D BY REGISTRAR <b>Oct. 25, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10710

THE STATE OF MARYLAND

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>		<p>3. AGE                  [REDACTED]</p>	
<p>4. DATE OF DEATH                  [REDACTED]</p>		<p>5. TIME OF DEATH                  [REDACTED]</p>		<p>6. PLACE OF DEATH                  [REDACTED]</p>	
<p>7. CAUSE OF DEATH                  [REDACTED]</p>		<p>8. MANNER OF DEATH                  [REDACTED]</p>		<p>9. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>10. SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>11. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED                  [REDACTED]</p>	

BUREAU V. S.

OCT 29 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10711

## CERTIFICATE OF DEATH

Reg. Dist. No.

10720  
302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>2 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARLOCK NURSING HOME</u>				d. STREET ADDRESS <u>MIDDLETOWN MD. R. 1</u>			
3. NAME OF DECEASED (Type or print) <u>JOSEPH C. HUTZELL</u>				4. DATE OF DEATH <u>OCTOBER - 9 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE - 20 - 1869</u> 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT - RETIRED GENERAL STORE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAMUEL HUTZELL</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH LAPOLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. JACK L. BAKER - 201 E. FRANKLIN ST.</u>				Address <u>HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 yrs</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10-1-1956</u> to <u>10-9-1956</u> , that I last saw the deceased alive on <u>10-3-56</u> , and that death occurred at <u>4-A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>[Signature]</u> DATE SIGNED <u>10/9/56</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) <u>BOONSBORO WASH. Co. MD</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>10/13/1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10712

## CERTIFICATE OF DEATH

10721

Reg. Dist. No. 302

## INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Washington</b>	MARYLAND	STATE <b>Pennsylvania</b>	COUNTY <b>Neville Township</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hagerstown</b>	LENGTH OF STAY (in this place) <b>5 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pittsburgh, 25</b>	<b>75 x 3</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Washington County Hospital</b>		STREET ADDRESS <b>7408 Yale Avenue</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>CHARLES</b> (Middle) <b>HENRY</b> (Last) <b>INGRAM</b>		(Month) <b>October 17,</b> (Day) <b>19</b> (Year) <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Widower</b>	8. DATE OF BIRTH <b>Jan. 17, 1891</b>
9. AGE last birthday <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if (temporarily) absent) <b>Maintenance Man Ret. Township</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hyndman, Penna.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Washington Ingram</b>		14. MOTHER'S MAIDEN NAME <b>Estella Marian Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS <b>Mrs. Lester Waters</b>		<b>RT.#1, Harpers Ferry, West Va.</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
260x IMMEDIATE CAUSE (A) <b>Diabetes Mellitus</b>			<b>2 years</b>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <b>Intestinal Obstruction</b>			<b>2 days</b>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct 14, 1956</b> , to <b>Oct 17, 1956</b> , that I last saw the deceased alive on <b>Oct 17, 1956</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Paul Harrison</b>		DATE SIGNED <b>Oct 17, 1956</b>	
ADDRESS (Street, city, town, state) <b>318 N. Potomac Hagerstown Md</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>10/20/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		LOCATION (City, town, or county) (State) <b>Samples Manor, Maryland</b>	
24. REC'D BY REGISTRAR <b>Oct 22, 1956</b>		REGISTRAR'S SIGNATURE <b>Donald Cackles</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Harpers Ferry</b>		ADDRESS <b>West Va.</b>	

# CERTIFICATE OF DEATH

Name of Deceased HARRISON, JAMES		Sex Male		Age 35	
Place of Birth Pittsburgh, Pa.		Race White		Date of Birth Jan. 12, 1891	
Cause of Death Pneumonia		Manner of Death Natural		Date of Death Oct. 17, 1956	
Place of Death Washington County Hospital		Signature of Physician J. H. Harrison		Signature of Registrar J. H. Harrison	
Name of Informant J. H. Harrison		Relationship Son		Address 1234 Main St., Baltimore, Md.	

BUREAU V. S.

OCT 24 1956

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10754

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mousetown		c. LENGTH OF STAY IN lb 45 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mousetown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 2 Boonsboro, Md.				d. STREET ADDRESS R # 2 Boonsboro, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Helen Catherine Itnyre				4. DATE OF DEATH Month Day Year October 1 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1975		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Hutzell				14. MOTHER'S MAIDEN NAME Elizabeth Lapole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Grayson Itnyre- R # 2 Boonsboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd & 3rd degree burns to entire body DUE TO upper and lower extremities Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Caught on fire while sitting in chair smoking a pipe					
20c. TIME OF INJURY Hour a. m. 7:30 p. m. Oct 1 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Rural Boonsboro, Wash Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-56		22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		22d. LOCATION (City, town, or county) (State) Boonsboro, Wash Md	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home- Boonsboro, Md.				24a. REC'D BY REGISTRAR DATE Oct 3, 1956		24b. REGISTRAR'S SIGNATURE John W. Bask	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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1956 8 OCT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10723

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1331 Jefferson Blvd.</u>				d. STREET ADDRESS <u>1331 Jefferson Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>CLEOPHUS</u> Last <u>KEYSER</u>				4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 20, 1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Clear Spring, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Mummert</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia Beard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Lester Keyser Hagerstown, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by drowning</u> <u>929.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Body found in cistern at residence</u>					
20c. TIME OF INJURY Hour <u>xxx</u> p. m. <u>Oct. 15 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) <u>Rural Hagerstown</u> (County) <u>Wash</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>10-16-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/18/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Ruyter</u> Super-Houzer Funeral Home Hagerstown, Maryland				24a. REC'D BY REGISTRAR <u>Oct. 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Heath Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 PHYSICIAN'S EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		POST-MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTY	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		STATE		COUNTY	

BUREAU V. 1

OCT 23 1956

RECEIVED

10714

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAMBERSBURG</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN HOSPITAL</u>		d. STREET ADDRESS <u>547 OAK ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ALICE</u> <u>Kotch</u>		4. DATE OF DEATH Month Day Year <u>OCT.</u> <u>1</u> , 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 8, 1923</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AIRCRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FAIRCHILD AIRCRAFT</u>	11. BIRTHPLACE (State or foreign country) <u>CHAMBERSBURG PA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES TRUETT</u>	
14. MOTHER'S MAIDEN NAME <u>MARY SHATZER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>195-16-3912</u>		17. INFORMANT <u>WILLIAM J. KOTCH</u> Address <u>547 OAK ST. CHAMBERSBURG, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous subarachnoid Hemorrhage</u> 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>✓</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 21</u> , 19 <u>56</u> , to <u>Oct. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 1</u> , 19 <u>56</u> , and that death occurred at <u>9:12 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>L. L. Packer, Jr.</u> M.D. <u>115 W. Washington St.</u> <u>10/2/56</u> PHYSICIAN'S NAME (Type) <u>L. L. Packer, Jr.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/4/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Corpus Christi</u>	22d. LOCATION (City, town, or county) (State) <u>Chambersburg</u> <u>Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u> Funeral Home <u>R. Franklin Rouzer</u>		24a. REC'D BY REGISTRAR DATE <u>Oct. 6, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10513

<p>1. Name of deceased: <i>JOHN ROBERT</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>1910</i></p>		<p>4. Place of birth: <i>Alabama</i></p>	
<p>5. Date of death: <i>1956</i></p>		<p>6. Place of death: <i>Birmingham</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of filing: <i>10/9/56</i></p>		<p>12. File number: <i>10513</i></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

## CERTIFICATE OF DEATH

Reg. Dist. No.

10725

303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 S. Prospect St.		d. STREET ADDRESS 221 S. Prospect St.	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Julius Lenzen		4. DATE OF DEATH Month Day Year October 24, 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector		10b. KIND OF BUSINESS OR INDUSTRY aircraft industry	
11. BIRTHPLACE (State or foreign country) Brooklyn, N. y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jospeh Lenzen		14. MOTHER'S MAIDEN NAME Ella Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 141-14-4065	
17. INFORMANT Mrs. Florence Lenzen, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Bronchus</i> 162X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 17, 1947</i> , to <i>Oct. 24, 1956</i> , that I last saw the deceased alive on <i>Oct 24, 1956</i> , and that death occurred at <i>6:05 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip J. Hirshman</i>		M.D. <i>159 W. Washington St., Hagerstown, Md.</i>	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		159 W. Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 10-27-56	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR Oct 29, 1956	
24b. REGISTRAR'S SIGNATURE <i>Chas H. Bowers</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1910		BALTIMORE		MD		USA		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		HISTORY		REMARKS	
JAN 15 1956		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		2 WEEKS		HOSPITAL		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

OCT 31 1956

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10755

## CERTIFICATE OF DEATH

Reg. Dist. No.

10726

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	c. LENGTH OF STAY IN 1b <u>2 months 12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>251 Fredrick Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>DONMOYER</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lebanon, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Donmoyer</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Lear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Catherine SAGLE Hancock, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic glomerular nephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>October 25 1956</u> , that I last saw the deceased alive on <u>October 25</u> , 19 <u>56</u> , and that death occurred at <u>6</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington Street</u> <u>10/26/56</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Kouzer Funeral Home</u>		ADDRESS <u>Hagerstown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Oct. 30, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Blair Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10752

<p>1. NAME OF DECEASED                  John Robinson</p>		<p>2. SEX                  Male</p>	
<p>3. RACE                  White</p>		<p>4. AGE                  65</p>	
<p>5. DATE OF DEATH                  October 1, 1956</p>		<p>6. TIME OF DEATH                  10:30 AM</p>	
<p>7. PLACE OF DEATH                  Baltimore, Maryland</p>		<p>8. CAUSE OF DEATH                  Coronary Thrombosis</p>	
<p>9. MANNER OF DEATH                  Natural</p>		<p>10. SIGNATURE OF PHYSICIAN                  [Signature]</p>	
<p>11. SIGNATURE OF WITNESS                  [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Signature]</p>	

BUREAU V. 3

OCT 31 1956

RECEIVED

10716

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>382 No Walnut St</u>				d. STREET ADDRESS <u>382 No Walnut St.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>LOWERY</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Shanandoah Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Meadows</u>				14. MOTHER'S MAIDEN NAME <u>Alice McCoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clifford Lowery</u> Address <u>Richmond Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cerebral vascular thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO <u>  </u> (c) <u>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs 3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-11-56</u> , 19 <u>  </u> , to <u>10-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-12-56</u> , 19 <u>  </u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. W. Ditto</u>				ADDRESS <u>Hagerstown Md</u> DATE SIGNED <u>10/13/56</u>			
PHYSICIAN'S NAME (Type) <u>E. W. Ditto</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 17, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phas H. Rowess</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

10717

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Conv. Home</u>				d. STREET ADDRESS <u>200 Mealey Parkway</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>C.</u> Last <u>Lowman</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-26-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Webster Lowman</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Woessner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-07-7918</u>		17. INFORMANT <u>Mrs. Robt. Treisler, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, generalized</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>53</u> , to <u>Oct. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 4</u> , 19 <u>56</u> , and that death occurred at <u>10 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				DATE SIGNED <u>194 W. Washington St. Hagerstown Md 10/15/56</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				<u>159 W. Washington St., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-6-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Royer</u>				ADDRESS <u>HAGERSTOWN, MD.</u>		24a. REC'D BY REGISTRAR <u>Oct. 6, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Gowers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH OCT 9 1956	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]	

RECEIVED  
 OCT 9 1956  
 BUREAU V. A.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10729

Reg. Dist. No. 302

10756

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>few minutes</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alleghany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>R. F. D. # 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JOHN</u> Middle <u>JAMES</u> Last <u>MARKEY</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>12</u> Year <u>1956</u>					
<b>5. SEX</b> <u>White</u>		<b>6. COLOR OR RACE</b> <u>Male</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 26, 1916</u>		<b>9. AGE</b> (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>16</u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Master Sargent</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U. S. Army</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Philadelphia, Penn.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John J. Markey</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Moore</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs. Erika Mattern Markey</u>		Address <u>Cumberland, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull - Hemorrhage &amp; Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car that crashed with truck and was pinned under truck</u>					
<b>20c. TIME OF INJURY</b> Hour <u>7:40</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>		Month, Day, Year <u>10-12-1956</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		<b>20f. (City or town)</b> <u>Rural - Hagerstown, Wash Md</u> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>10-13-56</u>	
<b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10/16/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cem.</u>			<b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Virginia</u> (State)		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>P. Franklin Ronger</u>				ADDRESS <u>Hagerstown, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Oct. 13, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Phasht Rowen</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

KANSAS STATE DEPARTMENT OF HEALTH - BATHMORE 18  
 STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF _____ CITY OF _____		DECEASED'S NAME _____ SEX _____ AGE _____	
DECEASED'S RESIDENCE _____ OCCUPATION _____		DATE OF DEATH _____ TIME OF DEATH _____	
PLACE OF DEATH _____ CAUSE OF DEATH _____		MANNER OF DEATH _____ (Natural, Accidental, Suicidal, Homicidal)	
SIGNATURE OF EXAMINER _____ EXAMINER'S NAME _____		SIGNATURE OF WITNESS _____ WITNESS'S NAME _____	

**BUREAU V. 8**

OCT 16 1956

**RECEIVED**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10718  
CERTIFICATE OF DEATH

Reg. Dist. No.

10730  
302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R.D.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY - LOUISE - MARTIN</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER - 19 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV - 28 - 1870</u>	
9. AGE (In years last birthday) <u>86-2-21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER PUBLIC SCHOOLS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BEAVER CREEK MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>ALBERT B. MARTIN</u>				14. MOTHER'S MAIDEN NAME <u>ANN M. TROUPE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>MISS MARY SHAFER</u>				Address <u>HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Generalized arteriosclerosis</u> DUE TO (b) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio-vascular disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 4, 1936</u> , to <u>Oct. 19, 1956</u> , that I last saw the deceased alive on <u>Oct. 19, 1956</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Ditto</u>				ADDRESS (Street, city or town, state) <u>217 W. Washington St.</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto</u>				DATE SIGNED <u>10/20/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FUNKSTOWN CEMERY</u>		22d. LOCATION (City, town, or county) <u>HAGERSTOWN WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Past Funeral Home</u>				ADDRESS <u>BOONSBORO MD.</u>		24. REC'D BY REGISTRAR <u>Oct. 24, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. Boward</u>							





OCT 24 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10720 CERTIFICATE OF DEATH

10732

Reg. Dist. No. 102

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <span style="float: right;">✓ MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b> <span style="float: right;">✓</span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Quincy Twp.</b> <span style="float: right;">75x-3</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>RD # 1, Waynesboro</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>MENTZER</b> Last <b>MENTZER</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>28,</b> Year <b>1956</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 8, 1922</b>		
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>34</b>		IF UNDER 24 HRS. Days <b>19</b> Hours <b>19</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry J. Mentzer</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Forthman</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>191-16-7936</b>		17. INFORMANT <b>Mrs. Ralph Mentzer, RD # 1, Waynesboro, Pa.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Glomerulonephritis, Acute</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 years</b> <b>1 month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>22 Oct., 1956</b> , to <b>28 Oct., 1956</b> , that I last saw the deceased alive on <b>28 Oct., 1956</b> , and that death occurred at <b>8:35 AM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Richard T. Blinford</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>28 Oct. 56</b>				
PHYSICIAN'S NAME (Type) <b>Richard T. Blinford</b>				<b>Hagerstown, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quincy Twp., Franklin Co., Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Marlin Roe</b>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR <b>DATE Oct. 30, 1956</b>		
				24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

OCT 31 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10733

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>			c. LENGTH OF STAY IN lb <b>few minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Boonsboro, Maryland</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>J.</b> Last <b>Mitchell</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>19 56</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15, 1890</b>		
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Boonsboro</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Mitchell</b>				14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>WW I War I</b>		16. SOCIAL SECURITY NO. <b>212-16-8047AB</b>		17. INFORMANT <b>Mrs. Pauline Mitchell - wife</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple open fractures lower extremities</b> DUE TO <b>Punctured wound abdominal cavity (Hemorrhage and shock)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian hit by oncoming car while walking in line of traffic</b>					
20c. TIME OF INJURY Hour <b>7:15</b> AM/PM <b>AM</b> Month, Day, Year <b>Oct. 12 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural- Boonsboro, Wash Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. Co. MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>BAST FUNERAL HOME BOONSBORO MARYLAND</b>				24a. REC'D BY REGISTRAR <b>DATE Oct. 15, 1956</b>		24b. REGISTRAR'S SIGNATURE <i>John H. Best</i>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G205 10-17-56 et

107558

## CERTIFICATE OF DEATH

10734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harpers Ferry, W.Va. Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home</b>				d. STREET ADDRESS <b>3301.4</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>May</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>IO</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>IO-4-1868</b>		9. AGE (In years last birthday) yrs. <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Reid</b>				14. MOTHER'S MAIDEN NAME <b>Susan Mitchell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mrs. Nellie Hovermale, Baltimore, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelo-nephritis</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/27/56</b> , 19__, to <b>10/5/56</b> , 19__, that I last saw the deceased alive on <b>10/4/56</b> , 19__, and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter H. Shady</b>				ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b>		DATE SIGNED <b>10/5/56</b>	
PHYSICIAN'S NAME (Type) <b>—</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>IO-8-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Felt</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 15 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elmer Byer</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 60		4. DATE OF BIRTH 1900		5. PLACE OF BIRTH Baltimore		6. OCCUPATION None	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH 10/15/56		11. TIME OF DEATH 10:00 AM		12. SIGNATURE OF PHYSICIAN J. H. Harris	
13. SIGNATURE OF REGISTRAR J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF FUNERAL HOME J. H. Harris		16. SIGNATURE OF CLERGYMAN J. H. Harris		17. SIGNATURE OF OTHER J. H. Harris		18. SIGNATURE OF OTHER J. H. Harris	

BUREAU V. 2

OCT 15 1956

RECEIVED



10721

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Bruce</u> Last <u>Morrison Sr.</u>				4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>		IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward G. Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Anna Cover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>705-10-5379</u>			
17. INFORMANT <u>Mrs. Evelyn Morrison</u>				Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>Carcinoma Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Liver</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hagerstown</u>				20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>10-22-56</u> to <u>10-22-56</u> , that I last saw the deceased alive on <u>10-22-56</u> , and that death occurred at <u>10-22-56</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fred W. Kraiss</u>				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Fred W. Kraiss</u>				DATE SIGNED <u>10/24/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 26, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Bowser</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04-210-0000  
12-00-0000

1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10722 Dr Wells  
CERTIFICATE OF DEATH

10736  
302

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>537 West Church St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BETTY</u> Middle <u>ELIZABETH</u> Last <u>NAIL</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 7 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gold</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Winkefield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Helen McNamee Hagerstown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic hypertensive vascular disease</u> <u>443X</u> DUE TO <u>Chronic glomerular nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial heart failure grade iv</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u> <u>7 yrs</u> <u>1 yr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I attended the deceased from <u>Oct. 13</u> , 19 <u>56</u> , to <u>Oct. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 13</u> , 19 <u>56</u> , and that death occurred at <u>5 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>S. Robert Wells</u> M.D. <u>115 N. Potomac Street</u> <u>10-16-56</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>Oct. 18, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		INDUSTRY	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
PREVIOUS ILLNESS		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
POST-MORTEM EXAMINATION		FINDINGS		OPINION		SIGNATURE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		TITLE OF EXAMINER	

BUREAU V. S.

OCT 22 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10723

## CERTIFICATE OF DEATH

Reg. Dist. No.

# 10737

# 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>50 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NO. 14 DOWNSVILLE ROAD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>WASHINGTON</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>NO. 14 DOWNSVILLE ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HARVEY MILLARD NUNAMAKER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>OCTOBER 18 1956</u>									
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>AUG-25-14-1869</u>		<b>9. AGE</b> (In years last birthday) <u>87-1-24</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months Days	Hours Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER - VICTOR PRODUCTS CORP. RETIRED</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NR. BOONSBORO WASH. Co. MD.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>REASON NUNAMAKER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH HOFFMAN</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>220-09-7875</u>				<b>17. INFORMANT</b> <u>SAMUEL NUNAMAKER 723 S. POTOMAC ST. HAGERSTOWN MD.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease</u> <u>420.0</u> DUE TO <u>myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>260X</u> (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 yrs +</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I attended the deceased from</b> <u>apr 1952</u> , to <u>18 Oct 1956</u> , that I last saw the deceased alive on <u>18 Oct 1956</u> , and that death occurred at <u>1130 P.M.</u> from the causes and on the date stated above.													
<b>ACTUAL SIGNATURE</b> <u>F. F. Lusby</u>				<b>ADDRESS</b> (Street, city or town, state) <u>230 N Potomac St Hagerstown Md</u>				<b>DATE SIGNED</b> <u>19 Oct 1956</u>					
<b>PHYSICIAN'S NAME</b> (Type) <u>F. F. Lusby</u>				<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>									
<b>22b. DATE THEREOF</b> <u>Oct 21 1956</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>REST HAVEN CEMETERY</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>HAGERSTOWN WASH. Co. MD</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>BAST FUNERAL HOME</u>				<b>ADDRESS</b> <u>BOONSBORO MD.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Oct 24 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Wash Bowers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

OCT 26 1956

RECEIVED

10724

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>354 South Locust Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>ROBERT</u> Last <u>ORCUTT</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 27, 1903</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Hagerstown</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Orcutt</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Krider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-09-2839</u>		17. INFORMANT Address <u>Mrs. Frances M. Orcutt Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis with Anginal Syndrome</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-24</u> , 19 <u>56</u> , to <u>10-4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>56</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Dalton M. Welty</u>				M.D. <u>998 Potomac Ave. Hagerstown Md. 10-5-</u>			
PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>				<u>Hagerstown, Md. Washington Co.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ringer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct 6. 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 10759 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## Dr Hirshman CERTIFICATE OF DEATH

Reg. Dist. No.

10739

303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 2</b> c. LENGTH OF STAY IN 1b <b>6 Mos</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>711 George St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>OVELMAN</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feby 12 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>		Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Martinsburg W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. McGinnis</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Cage</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert G. Ovelman Riverton Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senile and arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Sept 11</b> , 19 <b>50</b> , to <b>Oct 12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>56</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St. Hagerstown Md</b> DATE SIGNED <b>10/13/56</b> ACTUAL SIGNATURE <b>Philip J. Hirshman</b> PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/15/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Keyville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Keyville Carroll Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Oct 20 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy R. Fickler</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

OCT 29 1956

RECEIVED



10760

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Boonsboro</u>		LENGTH OF STAY (in this place) <u>6 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reeder's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>24 East Sixth Street</u>			
3. NAME OF DECEASED: (First) <u>Oliver</u> (Middle) <u>B.</u> (Last) <u>Palmer</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>October 6</u> 19 <u>56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb. 17, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months   Days	IF UNDER 24 HRS. Hours   Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Palmer</u>				14. MOTHER'S MAIDEN NAME: <u>Caroline (last name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT & ADDRESS: <u>Mrs. Stanley H. Rice (Same as item #2)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Polar Pneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S) <u>Generalized arteriosclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Diabetes mellitus</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 9, 1956</u> , to <u>Oct 6, 1956</u> , that I last saw the deceased alive on <u>Oct. 5, 1956</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Boonsboro</u>		DATE SIGNED <u>10/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9 Oct 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mountainview Cemetery</u>		LOCATION (City, town, or county) (State) <u>Union Bridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 9, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. I.

OCT 11 1956

RECEIVED

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10741

10725

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>14 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown Hospital</b>				d. STREET ADDRESS <b>Hagerstown #5</b>			
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Blanche</b> Last <b>Pepple</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>29,</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1887</b>		9. AGE (In years lost birthday) <b>68</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wissinger</b>				14. MOTHER'S MAIDEN NAME <b>Emma Brenner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>John R. Pepple, Hagerstown, Md. #5</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>586X Pulmonary Embolism</b> DUE TO <b>following: Cholecystectomy 2 wks ago.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 29, 1956</b> to <b>Oct 29, 56</b> , that I last saw the deceased alive on <b>Oct 29, 1956</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				ADDRESS (Street, city or town, state) <b>M.D. 159 W. Washington St., Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				DATE SIGNED <b>10/29/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Y. Hargis, Waynesboro, Pa.</b>				24a. REC'D BY REGISTRAR <b>Oct. 31, 1956</b>			
				24b. REGISTRAR'S SIGNATURE <b>W. Bowers</b>			

NOV 2 1956

RECEIVED

10761

## CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrotts Mills</b>				c. LENGTH OF STAY IN 1b <b>55 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural on farm</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>Rosetta</b> Last <b>Phillips</b>				4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1883</b>		9. AGE (In years last birthday) yrs. <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. Lowe</b>				14. MOTHER'S MAIDEN NAME <b>Kate Cross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Wm. H. Phillips</b> Address <b>Knoxville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-arachnoid hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Same.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-15-1956</b> to <b>10-15-1956</b> that I last saw the deceased alive on <b>10-15-1956</b> , and that death occurred at <b>4 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Garrotts Mills, Maryland</b> DATE SIGNED <b>10-15-56</b>							
ACTUAL SIGNATURE <b>C. E. Pruitt</b> M.D.				PHYSICIAN'S NAME (Type) <b>C. E. Pruitt</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10-18-56</b>		<b>Penticostal</b>		<b>Garrotts Mills, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Teets</b> ADDRESS <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR <b>007</b> DATE <b>24 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Lutherine Dayhart</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65		DATE OF BIRTH 1890	
PLACE OF BIRTH Maryland		OCCUPATION Farmer		EDUCATION High School		MARRIAGE Married	
DATE OF DEATH October 15, 1956		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
TIME OF DEATH 10:00 AM		TEMPERATURE 100.0		PULSE 100		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF FUNERAL HOME J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF DECEASED J. H. Harris	
DATE OF SIGNATURE October 15, 1956		DATE OF SIGNATURE October 15, 1956		DATE OF SIGNATURE October 15, 1956		DATE OF SIGNATURE October 15, 1956	

BUREAU V. S.

OCT 24 1956

RECEIVED

10762

## CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>27 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>N. MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES EDWARD POUND</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER - 19 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY - 2 - 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKIER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>CAKETOWN WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SILAS R. POUND</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SNECKENBERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-34-3413</u>		17. INFORMANT <u>MRS. BERTHA POUND</u> Address <u>BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>CARDIOVASCULAR COLLAPSE</u> Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary infarct in Feb. 1956</u> INTERVAL BETWEEN ONSET AND DEATH <u>min.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Oct. 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 12</u> , 19 <u>56</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Antietam St.</u> DATE SIGNED <u>10-19-56</u>							
ACTUAL SIGNATURE <u>Louis G. Graff</u> M.D. <u>119 E. Antietam St.</u>				DATE SIGNED <u>10-19-56</u>			
PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct. 22 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO MARYLAND</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOMIE</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>Oct. 22. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Dard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10553

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

BUREAU V. 1

OCT 24 1956

RECEIVED

10763

## CERTIFICATE OF DEATH

10744

Reg. Dist. No.

361

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, Md</u>		c. LENGTH OF STAY IN 1b <u>4 yrs 6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>B</u> Last <u>PROVARD</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel McPherson</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Fitz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT Address <u>Mrs. W. J. Santman Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 420.0 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>22 Aug</u> , 19 <u>56</u> , to <u>5 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 Oct</u> , 19 <u>56</u> , and that death occurred at <u>4:40</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>580 W. Potomac Street Williamsport Md</u> DATE SIGNED <u>Oct 11-1956</u>	
ACTUAL SIGNATURE <u>Paul Haack</u>		PHYSICIAN'S NAME (Type) <u>PAUL HAACK, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prices Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Waynesboro Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u> ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0764

## CERTIFICATE OF DEATH

10745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg</b>	
4. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>Pryor</b>		4. DATE OF DEATH <b>Oct. 22. 1956</b> 19 <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May. 6. 1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John R. Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Lillie A. Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Jennings D. Pryor</b>		Address <b>Lantz P.O. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO <b>12 years</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1948</b> to <b>Oct. 22, 1956</b> , that I last saw the deceased alive on <b>Oct. 22, 1956</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Kiefer</b> M.D.		ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa.</b> DATE SIGNED <b>22 Oct. 56</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Kiefer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 25th. 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Washington Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Breagan</b>		ADDRESS <b>Thurmont. Md</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 26 '56</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John A. Brown		Male		45 yrs	
Date of Death		Place of Death		Cause of Death	
Oct 26, 1956		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 26 1956

RECEIVED

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10726

## CERTIFICATE OF DEATH

Dr E.W. Ditto Jr. 10746

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>308 East Wilson Blvd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JEFFRY</u> Middle <u>LYNN</u> Last <u>SANDERS</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8 1956</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James R. Sanders</u>				14. MOTHER'S MAIDEN NAME <u>Nelva L. Ripple</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4----</u>		17. INFORMANT <u>James R. Sanders</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>771.0</u> DUE TO <u>Cerebral Hemorrhage (Congestive)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 days</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-8-1956</u> to <u>10-13-1956</u> , that I last saw the deceased alive on <u>10-17-56</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. W. Ditto Jr.</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>			
DATE SIGNED <u>10/13/56</u>							
PHYSICIAN'S NAME (Type) <u>E. W. Ditto Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew M. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 17, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

2081231XV3

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
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43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

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OCT 19 1956  
BUREAU V. B.

*[Handwritten signature]*  
BY  
[Signature]

Andrew K. Hollman, Registrar

10727

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 Year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 West Wilson Blvd</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOIS</b> Middle <b>LEONARD</b> Last <b>SANNER</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25 1897</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cedar Rapids Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Onar S. Leonard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Huff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rev George R. Sanner</b>		Address <b>14 W. Wilson Blvd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastasis to lungs, lumbar vertebrae and pelvic bones</b> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>to lungs, lumbar vertebrae and pelvic bones</b> DUE TO (c) <b>8 1/2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>-</b>				20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that I attended the deceased from <b>October 1955</b> , to <b>October 1956</b> , that I last saw the deceased alive on <b>Oct. 30 1956</b> , and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>			
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				DATE SIGNED <b>10-31-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-2-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>1003.1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>			

TO HOSPITAL: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. WILSON		45		Male		White		1936		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
14 West Wilson St.		Carpenter		Heart Disease		Natural		1936		Baltimore, Md.	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		EDUCATION		MARRIAGE DATE	
JAMES H. WILSON		MARY H. WILSON		1891		Maryland		High School		1915	
PREVIOUS ILLNESS		PHYSICIAN'S NAME		HOSPITAL NAME		HOSPITAL ADDRESS		DATE OF ADMISSION		DATE OF DISCHARGE	
None		Dr. J. H. Wilson		St. Mary's Hospital		1400 N. E. St.		1936		1936	
TESTIMONY OF PHYSICIAN		TESTIMONY OF WITNESSES		TESTIMONY OF CORONER		TESTIMONY OF MINISTER		TESTIMONY OF JURY		TESTIMONY OF JUDGE	
I certify that the above is a true and correct statement of the facts as they occurred.		I certify that the above is a true and correct statement of the facts as they occurred.		I certify that the above is a true and correct statement of the facts as they occurred.		I certify that the above is a true and correct statement of the facts as they occurred.		I certify that the above is a true and correct statement of the facts as they occurred.		I certify that the above is a true and correct statement of the facts as they occurred.	

BUREAU V. 2  
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ALTON K. COLMAN, Registrar

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Lloyd Hoffman

10748

10728

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>11 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>			d. STREET ADDRESS <u>1751 Preston Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL HAMMER SCHROEDER</u>			4. DATE OF DEATH Month Day Year <u>Oct. 4, 19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1897</u>	9. AGE (In years last birthday) yrs. <u>58</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maker</u>		11. BIRTHPLACE (State or foreign country) <u>Copenhagen, Denmark</u>	
13. FATHER'S NAME <u>Poul Hammer Schroeder</u>			14. MOTHER'S MAIDEN NAME <u>Elvina Lynge</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Edna Schroeder 1751 Preston Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>2 yrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Sept 4, 1956</u> , to <u>Oct 4, 1956</u> , that I last saw the deceased alive on <u>Oct 4, 1956</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>214 N. Pot. St.</u> <u>10/5/56</u> ACTUAL SIGNATURE <u>Clayton C. Hoffman</u> M.D. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u> <u>Hagerstown, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct. 6, 1956</u>
24b. REGISTRAR'S SIGNATURE <u>Clayton C. Hoffman</u>					



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10729

## CERTIFICATE OF DEATH

10749

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Mennonite Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abram</u> Middle <u>Shank</u> Last <u>Shank</u>			4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1872</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Shank</u>				14. MOTHER'S MAIDEN NAME <u>Mary Strite</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Mrs. Samuel Horst</u>		Address <u>Hagerstown RT#4 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181X</u> DUE TO <u>Carcinoma Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-1-56</u> 19 <u>  </u> to <u>10-10-56</u> 19 <u>  </u> that I last saw the deceased alive on <u>10-16-56</u> 19 <u>  </u> and that death occurred at <u>3:30 p.m.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. W. Smith</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>		DATE SIGNED <u>10/17/56</u>	
PHYSICIAN'S NAME (Type) <u>A. W. Smith</u>				<u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reiff Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Norment</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 13, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Bowers</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1910</b>		5. PLACE OF BIRTH <b>NEW YORK</b>	
6. OCCUPATION <b>CLERK</b>		7. MARITAL STATUS <b>MARRIED</b>		8. DATE OF MARRIAGE <b>1935</b>		9. PLACE OF MARRIAGE <b>NEW YORK</b>		10. NAME OF SPOUSE <b>MARY J. BROWN</b>	
11. CAUSE OF DEATH <b>HEART DISEASE</b>		12. PLACE OF DEATH <b>NEW YORK</b>		13. DATE OF DEATH <b>1956</b>		14. TIME OF DEATH <b>10:00 AM</b>		15. SIGNATURE OF DECEASED <b>[Signature]</b>	
16. SIGNATURE OF WITNESS <b>[Signature]</b>		17. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		18. SIGNATURE OF MINISTER <b>[Signature]</b>		19. SIGNATURE OF CORONER <b>[Signature]</b>		20. SIGNATURE OF JURY <b>[Signature]</b>	

BUREAU V. S.

OCT 16 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10750

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - R # 64		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkettville 10x-2	
c. LENGTH OF STAY IN 1b working		d. STREET ADDRESS -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Leroy Last Shank		4. DATE OF DEATH Month Oct. Day 19 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1933
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Wk	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George F. Shank		14. MOTHER'S MAIDEN NAME Annabelle Rohrback	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-28-6309	
17. INFORMANT Mrs. James L. Shank - Burkittsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest - hemorrhage & shock DUE TO Closed fracture lt. hand Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed beneath a falling grading machine	
20c. TIME OF INJURY Month, Day, Year Hour XXX Oct. 19 56 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Rural Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED 10-20-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-21-56	22c. NAME OF CEMETERY OR CREMATORY Brethren Cemetery	22d. LOCATION (City, town, or county) (State) Brownsville Wash Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co. Middletown, Md.		24a. REC'D BY REGISTRAR Oct. 23 1956	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

21

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

9561 28 OCT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonesboro</b>				c. LENGTH OF STAY IN 1b <b>2 Mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Nursing Home</b>				d. STREET ADDRESS <b>311 Bryan Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>CATHERINE</b> Last <b>SHANK</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>4</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1875</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin County, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Albert Carbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Strong</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. H. E. Swope</b> Address <b>311 Bryan Place Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boonesboro</b>	
				20f. (City or town) <b>Boonesboro</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 3</b> , 19 <b>56</b> , to <b>Oct 4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct 3</b> , 19 <b>56</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonesboro</b> DATE SIGNED ACTUAL SIGNATURE <b>G. W. LeVan</b> M.D. PHYSICIAN'S NAME (Type) <b>Gerald W. LeVan M.D.</b> <b>Boonesboro, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 6, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 10 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John D. Burt</b>	

*W. J. Van, C. H. H. H. H. H.*

0 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

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10730

CERTIFICATE OF DEATH

Dr E.W. Dotto Jr

10752

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>6 Weeks</b>		d. STREET ADDRESS <b>906 Maryland Ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Mem. Conv. Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>-----</b> Last <b>SHAW</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>30</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 4 1874</b>
9. AGE (In years lost birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>North Mountain W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Shaw</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Holmes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Charles S. Shaw</b>		Address <b>1715 Preston Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>General arterial sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-1-36</b> , 19 <b>36</b> , to <b>10-30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10-30-56</b> , 19 <b>56</b> , and that death occurred at <b>7:4</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr E.W. Dotto Jr</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr E.W. Dotto Jr</b>		DATE SIGNED <b>Nov 19 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-1-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov 2, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10731 Item 8 Fil#0205 10-30-56 et

Reg. Dist. No.

10753

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>15 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Shumaker</u>		4. DATE OF DEATH Month Day Year <u>Oct 16 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896 June 11, 1895</u>
9. AGE (In years last birthday) <u>60 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Power Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin Shumaker</u>		14. MOTHER'S MAIDEN NAME <u>Annie Hutzell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-3995</u>	
17. INFORMANT <u>Mrs. Anna May Shumaker</u>		Address <u>Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mangled lower abdomen and right hip joint region</u> <u>912.3</u> DUE TO (b) <u>(Hemorrhage and shock)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crane fell on patient</u>	
20c. TIME OF INJURY Month, Day, Year <u>Oct. 16 1956</u> Hour <u>12:45</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat white <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-17-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-19-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct. 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>S. Robert Wells</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
c. LENGTH OF STAY IN 1b <u>About week</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Fenton Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Benjamin Slick</u>			4. DATE OF DEATH Month Day Year <u>Oct. 10 1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1887</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>10 24</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Wasser Motor Express Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Benjamin Slick</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Zigler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-0322</u>		17. INFORMANT Address <u>Mrs. Jack Conley Hagerstown Md RFD #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Day</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/10/56</u> , 19 <u>56</u> to <u>10/10/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/10/56</u> , 19 <u>56</u> , and that death occurred at <u>10:57</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Williamsport Md 10/10/56</u>							
ACTUAL SIGNATURE <u>Reg Hager</u> M.D.				PHYSICIAN'S NAME (Type) <u>Reg Hager</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>				24a. REC'D BY REGISTRAR <u>Oct. 12 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Oct 10 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>Oct 15 1911</i>		11. TIME OF BIRTH <i>10:00 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF FATHER <i>John Doe</i>		14. NAME OF MOTHER <i>John Doe</i>		15. NAME OF SPOUSE <i>John Doe</i>	
16. NAME OF CHILDREN <i>John Doe</i>		17. NAME OF CHILDREN <i>John Doe</i>		18. NAME OF CHILDREN <i>John Doe</i>	
19. NAME OF CHILDREN <i>John Doe</i>		20. NAME OF CHILDREN <i>John Doe</i>		21. NAME OF CHILDREN <i>John Doe</i>	
22. NAME OF CHILDREN <i>John Doe</i>		23. NAME OF CHILDREN <i>John Doe</i>		24. NAME OF CHILDREN <i>John Doe</i>	
25. NAME OF CHILDREN <i>John Doe</i>		26. NAME OF CHILDREN <i>John Doe</i>		27. NAME OF CHILDREN <i>John Doe</i>	
28. NAME OF CHILDREN <i>John Doe</i>		29. NAME OF CHILDREN <i>John Doe</i>		30. NAME OF CHILDREN <i>John Doe</i>	
31. NAME OF CHILDREN <i>John Doe</i>		32. NAME OF CHILDREN <i>John Doe</i>		33. NAME OF CHILDREN <i>John Doe</i>	
34. NAME OF CHILDREN <i>John Doe</i>		35. NAME OF CHILDREN <i>John Doe</i>		36. NAME OF CHILDREN <i>John Doe</i>	
37. NAME OF CHILDREN <i>John Doe</i>		38. NAME OF CHILDREN <i>John Doe</i>		39. NAME OF CHILDREN <i>John Doe</i>	
40. NAME OF CHILDREN <i>John Doe</i>		41. NAME OF CHILDREN <i>John Doe</i>		42. NAME OF CHILDREN <i>John Doe</i>	
43. NAME OF CHILDREN <i>John Doe</i>		44. NAME OF CHILDREN <i>John Doe</i>		45. NAME OF CHILDREN <i>John Doe</i>	
46. NAME OF CHILDREN <i>John Doe</i>		47. NAME OF CHILDREN <i>John Doe</i>		48. NAME OF CHILDREN <i>John Doe</i>	
49. NAME OF CHILDREN <i>John Doe</i>		50. NAME OF CHILDREN <i>John Doe</i>		51. NAME OF CHILDREN <i>John Doe</i>	
52. NAME OF CHILDREN <i>John Doe</i>		53. NAME OF CHILDREN <i>John Doe</i>		54. NAME OF CHILDREN <i>John Doe</i>	
55. NAME OF CHILDREN <i>John Doe</i>		56. NAME OF CHILDREN <i>John Doe</i>		57. NAME OF CHILDREN <i>John Doe</i>	
58. NAME OF CHILDREN <i>John Doe</i>		59. NAME OF CHILDREN <i>John Doe</i>		60. NAME OF CHILDREN <i>John Doe</i>	
61. NAME OF CHILDREN <i>John Doe</i>		62. NAME OF CHILDREN <i>John Doe</i>		63. NAME OF CHILDREN <i>John Doe</i>	
64. NAME OF CHILDREN <i>John Doe</i>		65. NAME OF CHILDREN <i>John Doe</i>		66. NAME OF CHILDREN <i>John Doe</i>	
67. NAME OF CHILDREN <i>John Doe</i>		68. NAME OF CHILDREN <i>John Doe</i>		69. NAME OF CHILDREN <i>John Doe</i>	
70. NAME OF CHILDREN <i>John Doe</i>		71. NAME OF CHILDREN <i>John Doe</i>		72. NAME OF CHILDREN <i>John Doe</i>	
73. NAME OF CHILDREN <i>John Doe</i>		74. NAME OF CHILDREN <i>John Doe</i>		75. NAME OF CHILDREN <i>John Doe</i>	
76. NAME OF CHILDREN <i>John Doe</i>		77. NAME OF CHILDREN <i>John Doe</i>		78. NAME OF CHILDREN <i>John Doe</i>	
79. NAME OF CHILDREN <i>John Doe</i>		80. NAME OF CHILDREN <i>John Doe</i>		81. NAME OF CHILDREN <i>John Doe</i>	
82. NAME OF CHILDREN <i>John Doe</i>		83. NAME OF CHILDREN <i>John Doe</i>		84. NAME OF CHILDREN <i>John Doe</i>	
85. NAME OF CHILDREN <i>John Doe</i>		86. NAME OF CHILDREN <i>John Doe</i>		87. NAME OF CHILDREN <i>John Doe</i>	
88. NAME OF CHILDREN <i>John Doe</i>		89. NAME OF CHILDREN <i>John Doe</i>		90. NAME OF CHILDREN <i>John Doe</i>	
91. NAME OF CHILDREN <i>John Doe</i>		92. NAME OF CHILDREN <i>John Doe</i>		93. NAME OF CHILDREN <i>John Doe</i>	
94. NAME OF CHILDREN <i>John Doe</i>		95. NAME OF CHILDREN <i>John Doe</i>		96. NAME OF CHILDREN <i>John Doe</i>	
97. NAME OF CHILDREN <i>John Doe</i>		98. NAME OF CHILDREN <i>John Doe</i>		99. NAME OF CHILDREN <i>John Doe</i>	
100. NAME OF CHILDREN <i>John Doe</i>		101. NAME OF CHILDREN <i>John Doe</i>		102. NAME OF CHILDREN <i>John Doe</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10733** Item 14 Film 206 11-7-56 et  
**CERTIFICATE OF DEATH**

10755

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>401 Pangborn Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>BELIE</u> Last <u>SLICK</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 27, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
13. FATHER'S NAME <u>Harry Swartz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Harry L. Slick Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive - arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u>Arteriolar nephrosclerosis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>  <u>? 18 yrs.</u>  <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <del>10 years prior to terminal disease</del>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>6/5/44</u> , 19 <u>  </u> , to <u>10/30/56</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>10/30/56</u> , 19 <u>  </u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Md.</u> DATE SIGNED <u>10:31:56</u>							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/2/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u> <u>R. E. Suter</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 2, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>B. H. Bowers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
PREVIOUS TOBACCO		PREVIOUS SMOKE		PREVIOUS CIGARETTES		PREVIOUS PIPE		PREVIOUS OTHER	
PREVIOUS MEDICATION		PREVIOUS TREATMENT		PREVIOUS HOSPITAL		PREVIOUS PHYSICIAN		PREVIOUS NURSE	
PREVIOUS SURGEON		PREVIOUS ANESTHESIA		PREVIOUS OPERATIONS		PREVIOUS RESULTS		PREVIOUS COMMENTS	
PREVIOUS EXAMINER		PREVIOUS SIGNATURE		PREVIOUS DATE		PREVIOUS PLACE		PREVIOUS OTHER	
PREVIOUS NAME		PREVIOUS ADDRESS		PREVIOUS CITY		PREVIOUS STATE		PREVIOUS ZIP	
PREVIOUS PHONE		PREVIOUS TELETYPE		PREVIOUS TELEGRAPH		PREVIOUS RADIO		PREVIOUS OTHER	
PREVIOUS MAIL		PREVIOUS CABLE		PREVIOUS AIR		PREVIOUS SEA		PREVIOUS LAND	
PREVIOUS RAIL		PREVIOUS ROAD		PREVIOUS TRAIL		PREVIOUS PATH		PREVIOUS OTHER	
PREVIOUS FERRY		PREVIOUS BOAT		PREVIOUS PLANE		PREVIOUS CAR		PREVIOUS OTHER	
PREVIOUS BUS		PREVIOUS TAXI		PREVIOUS RENTAL		PREVIOUS OWNED		PREVIOUS OTHER	
PREVIOUS TRUCK		PREVIOUS TRAILER		PREVIOUS SEMI		PREVIOUS VAN		PREVIOUS OTHER	
PREVIOUS MOTORCYCLE		PREVIOUS BICYCLE		PREVIOUS SKI		PREVIOUS BOAT		PREVIOUS OTHER	
PREVIOUS AIRCRAFT		PREVIOUS SPACE		PREVIOUS SUBMERSIBLE		PREVIOUS OTHER		PREVIOUS COMMENTS	
PREVIOUS SIGNATURE		PREVIOUS DATE		PREVIOUS PLACE		PREVIOUS OTHER		PREVIOUS COMMENTS	
PREVIOUS NAME		PREVIOUS ADDRESS		PREVIOUS CITY		PREVIOUS STATE		PREVIOUS ZIP	
PREVIOUS PHONE		PREVIOUS TELETYPE		PREVIOUS TELEGRAPH		PREVIOUS RADIO		PREVIOUS OTHER	
PREVIOUS MAIL		PREVIOUS CABLE		PREVIOUS AIR		PREVIOUS SEA		PREVIOUS LAND	
PREVIOUS RAIL		PREVIOUS ROAD		PREVIOUS TRAIL		PREVIOUS PATH		PREVIOUS OTHER	
PREVIOUS FERRY		PREVIOUS BOAT		PREVIOUS PLANE		PREVIOUS CAR		PREVIOUS OTHER	
PREVIOUS BUS		PREVIOUS TAXI		PREVIOUS RENTAL		PREVIOUS OWNED		PREVIOUS OTHER	
PREVIOUS TRUCK		PREVIOUS TRAILER		PREVIOUS SEMI		PREVIOUS VAN		PREVIOUS OTHER	
PREVIOUS MOTORCYCLE		PREVIOUS BICYCLE		PREVIOUS SKI		PREVIOUS BOAT		PREVIOUS OTHER	
PREVIOUS AIRCRAFT		PREVIOUS SPACE		PREVIOUS SUBMERSIBLE		PREVIOUS OTHER		PREVIOUS COMMENTS	

RECEIVED  
JUN 5 1956  
BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756

10734

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN Tb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 W. Church St.,</b>				d. STREET ADDRESS <b>401 W. Church St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dewey</b>		First <b>Clinton</b>		Middle <b>Stanley</b>		Last <b>Stanley</b>	
4. DATE OF DEATH <b>10</b> <b>90</b> <b>1956</b>		Month <b>10</b> Day <b>90</b> Year <b>1956</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12, 1898</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>		IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ernest Stanley</b>				14. MOTHER'S MAIDEN NAME <b>Ella Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-16-0201</b>		17. INFORMANT <b>Mrs. Ella Stanley</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>490x</b> (a), stating the underlying cause last. DUE TO (c) <b>322.2 Alcoholism</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>322.2 Alcoholism</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m. <b>none</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-12-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, lawn, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> Address <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Oct 14, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

CERTIFICATE OF DEATH

10757

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>				c. LENGTH OF STAY IN 1b <b>Life time</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>300 N. Jonathan Street.</b>				d. STREET ADDRESS <b>300 N. Jonathan Street.</b>			
3. NAME OF DECEASED (Type or print) First <b>Maryland</b> Middle <b>Elizabeth</b> Last <b>Stanley</b>				4. DATE OF DEATH Month <b>10</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 4 1903</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11. BIRTHPLACE (State or foreign country) <b>Magerstown Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>							
13. FATHER'S NAME <b>Frank Woodford</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Matilda</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-32-4951</b>		17. INFORMANT <b>Charles Perkins</b> Address <b>300 N. Jonathan St..</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis CVD.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1/11/56</b> , 19____, to <b>9/26/56</b> , 19____, that I last saw the deceased alive on <b>9/26/56</b> , 19____, and that death occurred at <b>12</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 N. Potomac St., Hagerstown, Maryland</b> DATE SIGNED <b>10/22/56</b> ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-24-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr</b>				ADDRESS <b>Hagerstown Md</b>		24a. REC'D BY REGISTRAR <b>Oct 25 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF TOWNSHIP CLERK		23. SIGNATURE OF TOWNSHIP SHERIFF		24. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
25. SIGNATURE OF TOWNSHIP CONSTABLE		26. SIGNATURE OF TOWNSHIP CLERK		27. SIGNATURE OF TOWNSHIP SHERIFF	
28. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		29. SIGNATURE OF TOWNSHIP CONSTABLE		30. SIGNATURE OF TOWNSHIP CLERK	
31. SIGNATURE OF TOWNSHIP SHERIFF		32. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		33. SIGNATURE OF TOWNSHIP CONSTABLE	
34. SIGNATURE OF TOWNSHIP CLERK		35. SIGNATURE OF TOWNSHIP SHERIFF		36. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
37. SIGNATURE OF TOWNSHIP CONSTABLE		38. SIGNATURE OF TOWNSHIP CLERK		39. SIGNATURE OF TOWNSHIP SHERIFF	
40. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		41. SIGNATURE OF TOWNSHIP CONSTABLE		42. SIGNATURE OF TOWNSHIP CLERK	
43. SIGNATURE OF TOWNSHIP SHERIFF		44. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		45. SIGNATURE OF TOWNSHIP CONSTABLE	
46. SIGNATURE OF TOWNSHIP CLERK		47. SIGNATURE OF TOWNSHIP SHERIFF		48. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
49. SIGNATURE OF TOWNSHIP CONSTABLE		50. SIGNATURE OF TOWNSHIP CLERK		51. SIGNATURE OF TOWNSHIP SHERIFF	
52. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		53. SIGNATURE OF TOWNSHIP CONSTABLE		54. SIGNATURE OF TOWNSHIP CLERK	
55. SIGNATURE OF TOWNSHIP SHERIFF		56. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		57. SIGNATURE OF TOWNSHIP CONSTABLE	
58. SIGNATURE OF TOWNSHIP CLERK		59. SIGNATURE OF TOWNSHIP SHERIFF		60. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
61. SIGNATURE OF TOWNSHIP CONSTABLE		62. SIGNATURE OF TOWNSHIP CLERK		63. SIGNATURE OF TOWNSHIP SHERIFF	
64. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		65. SIGNATURE OF TOWNSHIP CONSTABLE		66. SIGNATURE OF TOWNSHIP CLERK	
67. SIGNATURE OF TOWNSHIP SHERIFF		68. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		69. SIGNATURE OF TOWNSHIP CONSTABLE	
70. SIGNATURE OF TOWNSHIP CLERK		71. SIGNATURE OF TOWNSHIP SHERIFF		72. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
73. SIGNATURE OF TOWNSHIP CONSTABLE		74. SIGNATURE OF TOWNSHIP CLERK		75. SIGNATURE OF TOWNSHIP SHERIFF	
76. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		77. SIGNATURE OF TOWNSHIP CONSTABLE		78. SIGNATURE OF TOWNSHIP CLERK	
79. SIGNATURE OF TOWNSHIP SHERIFF		80. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		81. SIGNATURE OF TOWNSHIP CONSTABLE	
82. SIGNATURE OF TOWNSHIP CLERK		83. SIGNATURE OF TOWNSHIP SHERIFF		84. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
85. SIGNATURE OF TOWNSHIP CONSTABLE		86. SIGNATURE OF TOWNSHIP CLERK		87. SIGNATURE OF TOWNSHIP SHERIFF	
88. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		89. SIGNATURE OF TOWNSHIP CONSTABLE		90. SIGNATURE OF TOWNSHIP CLERK	
91. SIGNATURE OF TOWNSHIP SHERIFF		92. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		93. SIGNATURE OF TOWNSHIP CONSTABLE	
94. SIGNATURE OF TOWNSHIP CLERK		95. SIGNATURE OF TOWNSHIP SHERIFF		96. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF	
97. SIGNATURE OF TOWNSHIP CONSTABLE		98. SIGNATURE OF TOWNSHIP CLERK		99. SIGNATURE OF TOWNSHIP SHERIFF	
100. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF		101. SIGNATURE OF TOWNSHIP CONSTABLE		102. SIGNATURE OF TOWNSHIP CLERK	

BUREAU V. 4

OCT 29 1956

RECEIVED

John R. Watson of Boston, MA

10736

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>533 North Locust Street</u>				d. STREET ADDRESS <u>533 North Locust Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Antonio</u> Middle <u>(none)</u> Last <u>Suranno</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1887</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Well Digger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Quarry</u>		11. BIRTHPLACE (State or foreign country) <u>Bisuccia, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. -1944</u>	
13. FATHER'S NAME <u>Michael Suranno</u>				14. MOTHER'S MAIDEN NAME <u>Rose Iorio</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-6877A</u>		17. INFORMANT Address <u>Mrs. Rose Mazzo, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaplastic Carcinoma of Bladder</u> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 36, 19</u> to <u>Oct 18, 1956</u> , that I last saw the deceased alive on <u>Oct 18, 1956</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. H. Campbell</u> M.D.		ADDRESS (Street, city or town, state) <u>145W Washington St</u>				DATE SIGNED <u>10/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>		<u>Hagerstown Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-22-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Lanphier Ringer</u>		ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert V. H. Campbell</u>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992

1000

10/10/1984

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2. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

BUREAU V. S.

OCT 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10759

10737

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>223 Mill St.</b>		d. STREET ADDRESS <b>223 Mill St.</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>E</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	9. AGE (In years last birthday) yrs. <b>66</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Al Miller</b>		14. MOTHER'S MAIDEN NAME <b>Alice Weller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. John H. Thomas</b>		223 Mill St. <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF UTERUS</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o. 11</b> Month <b>19</b> Day <b>19</b> Year <b>1956</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-25-</b> 19 <b>56</b> to <b>10-3-</b> 19 <b>56</b> that I last saw the deceased alive on <b>October 3</b> 19 <b>56</b> , and that death occurred at <b>3:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St Hagerstown Md</b> DATE SIGNED <b>10/3/57</b>			
ACTUAL SIGNATURE <b>Paul Harrison</b>		M.D. <b>318 N. Potomac St Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HARRISON MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/6/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 5 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>Chas. Bowers</b>	





10767

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE - RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE RURAL</u>			
c. LENGTH OF STAY IN 1b <u>48 YEARS</u>				d. STREET ADDRESS <u>BROWNSVILLE MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROWNSVILLE MD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LENA - MAY - THOMPSON</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER - 27 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY - 20 - 1890</u>	
9. AGE (In years last birthday) <u>66-8-7</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LEE TOWN WV. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY ISELIN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE L. DAVIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONIC</u>		17. INFORMANT Address <u>EDWARD F. THOMPSON BROWNSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4202</u> DUE TO <u>Acute angina</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Essential hypertension -</u> (b) <u>20 yrs.</u> (c) <u>30 mmh</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 29</u> , 19 <u>56</u> , to <u>Oct 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u>				ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				DATE SIGNED <u>10/29/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct. 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CH. OF THE BRETHREN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BAST FUNERAL HOME BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR DATE <u>Oct. 31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Katherine Loggins</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JUDGE [Faint text]	
17. SIGNATURE OF CLERK [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]	
19. SIGNATURE OF [Faint text] [Faint text]		20. SIGNATURE OF [Faint text] [Faint text]	
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89. SIGNATURE OF [Faint text] [Faint text]		90. SIGNATURE OF [Faint text] [Faint text]	
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95. SIGNATURE OF [Faint text] [Faint text]		96. SIGNATURE OF [Faint text] [Faint text]	
97. SIGNATURE OF [Faint text] [Faint text]		98. SIGNATURE OF [Faint text] [Faint text]	
99. SIGNATURE OF [Faint text] [Faint text]		100. SIGNATURE OF [Faint text] [Faint text]	

BUREAU Y. E.

NOV 2 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10738

CERTIFICATE OF DEATH

10761

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>9402 Crosby Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>O.</u> Last <u>TOTTON</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>11</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C. Railroad Terminal</u>		11. BIRTHPLACE (State or foreign country) <u>Mechanicsburg, Pa.</u>	
13. FATHER'S NAME <u>George B. Totton</u>				14. MOTHER'S MAIDEN NAME <u>Laura Ogilby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>George Gerbig</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer Prostate</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sev. days</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9/14/</u> 19 <u>56</u> , to <u>10/29/</u> 19 <u>56</u> , that I last saw the deceased alive on <u>10/29/</u> 19 <u>56</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>				ADDRESS (Street, city or town, state) <u>136 North Potomac St.</u>			
DATE SIGNED <u>10/31/56</u>							
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>10/31/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles H. Powers</u>			

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18  
10739 CERTIFICATE OF DEATH Dr. B. B. Kneisley

10762

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>633 No Mulberry St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD FRANKLIN TROVINGER</u>		4. DATE OF DEATH Month Day Year <u>Oct 25 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1878</u>
9. AGE (In years lost birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Moller Inc</u>	
11. PLACE OF BIRTH (State and foreign birth) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Trovinger</u>		14. MOTHER'S MAIDEN NAME <u>Susan Eakle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>214-09-3854</u>	
17. INFORMANT <u>Mrs Roena Trovinger</u>		Address <u>633 No Mulberry St Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; benign prostatic hypertrophy and nephrolithiasis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , to <u>Oct. 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 25</u> , 19 <u>56</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington Street 10/26/56</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct. 29. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	



# CERTIFICATE OF DEATH

STATE OF TEXAS, COUNTY OF HARRIS, CITY OF HOUSTON

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
JAMES EARL RAY		Male		35		1928		Memphis, Tennessee		Suicide		Shot with a .38 Smith & Wesson revolver		April 4, 1968		Houston, Texas		10:00 AM		JAMES EARL RAY		JAMES EARL RAY	
Occupation		Education		Marital Status		Previous Residence		Previous Address		Previous Telephone		Previous Hospital		Previous Doctor		Previous Nurse		Previous Priest		Previous Minister		Previous Chaplain	
None		High School		Single		None		None		None		None		None		None		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Scientist		Signature of Toxicologist		Signature of Anthropologist		Signature of Archaeologist		Signature of Historian	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

OCT 31 1956

RECEIVED

Andrew K. Goltz, Harris County, Texas

10740

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>29 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>RAYMOND</b> Last <b>WASTLER</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/24/1903</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOOL MAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES BERNARD WASTLER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET WEBB</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-6877</b>		17. INFORMANT <b>MRS? LILLIE WASTLER</b>		Address <b>RT. #6 HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>260X</b> DUE TO <b>Coronary Artery occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> (c) <b>3 1/2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>5 min</b> <b>3 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-6-55</b> , 19____, to <b>10-2-56</b> , 19____, that I last saw the deceased alive on <b>9-6-56</b> , 19____, and that death occurred at <b>5:30 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>10/4/56</b>							
ACTUAL PHYSICIAN'S NAME (Type) <b>SEARL YOUNG M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/5/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BROADFORDING CHURCH</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 9 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10741

## CERTIFICATE OF DEATH

Reg. Dist. No.

10765

302

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>13 N. MULBERRY ST.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CATHERINE</b> Middle <b>IRENE</b> Last <b>WEITZEL</b>		<b>4. DATE OF DEATH</b> Month <b>OCTOBER</b> Day <b>3</b> Year <b>19 56</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2/3/1904</b>
<b>9. AGE</b> (In years last birthday) <b>52 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOME</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>LEWIS M. JONES</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>NORA THOMPSON</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <b>214-09-5057</b>		<b>17. INFORMANT</b> Address <b>HAGERSTOWN MD.</b> <b>MR. LUTHER WEITZEL</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of cervix</b> DUE TO (b) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 yrs.</b>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <b>Sept</b> , 1957, to <b>3 Oct</b> , 1957, that I last saw the deceased alive on <b>3 Oct</b> , 1957, and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>Eldon S. Howland</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>115 W. Wash. St.</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>Eldon S. Howland</b>		<b>Hagerstown Md.</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>	<b>22b. DATE THEREOF</b> <b>10/6/56</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>REST HAVEN CEM.</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>W. J. Horne, Hagerstown, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>Oct. 9. 1956</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles H. Bowers</b>

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. JONES		AGE 37		SEX Male		RACE White		DATE OF BIRTH 1919		PLACE OF BIRTH Mississippi	
DECEASED AT Washington County Hospital		CITY Washington		STATE Mississippi		COUNTY Washington		DATE OF DEATH October 15, 1956		PLACE OF DEATH Washington County Hospital	
CAUSE OF DEATH Suicide		MANNER OF DEATH Suicide		DISEASE OR INJURY Suicide		SYMPTOMS Suicide		TREATMENT Suicide		POST-MORTEM Suicide	
SIGNATURE OF PHYSICIAN JAMES M. JONES		SIGNATURE OF WITNESS JAMES M. JONES		SIGNATURE OF DECEASED JAMES M. JONES		SIGNATURE OF NEXT OF KIN JAMES M. JONES		SIGNATURE OF CLERK JAMES M. JONES		SIGNATURE OF JURY JAMES M. JONES	
DATE OF DEATH October 15, 1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH Washington County Hospital		CITY Washington		STATE Mississippi		COUNTY Washington	
CAUSE OF DEATH Suicide		MANNER OF DEATH Suicide		DISEASE OR INJURY Suicide		SYMPTOMS Suicide		TREATMENT Suicide		POST-MORTEM Suicide	
SIGNATURE OF PHYSICIAN JAMES M. JONES		SIGNATURE OF WITNESS JAMES M. JONES		SIGNATURE OF DECEASED JAMES M. JONES		SIGNATURE OF NEXT OF KIN JAMES M. JONES		SIGNATURE OF CLERK JAMES M. JONES		SIGNATURE OF JURY JAMES M. JONES	
DATE OF DEATH October 15, 1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH Washington County Hospital		CITY Washington		STATE Mississippi		COUNTY Washington	

BUREAU V. 2

OCT 15 1956

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10742**  
**CERTIFICATE OF DEATH**

**10766**

Reg. Dist. No. **302**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Washington</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>			c. LENGTH OF STAY IN 1b <b>55yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 W. Bethel Street</b>				d. STREET ADDRESS <b>31 W. Bethel Street.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Charles Nathan William</b>				<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>12</b> Year <b>1956</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Mar 11 1887</b>		<b>9. AGE</b> (In years last birthday) <b>69 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Boilermaker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Steam railroad</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Fort Frederick, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>	
<b>13. FATHER'S NAME</b> <b>Samuel William</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nanne William</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <b>705-10-4610</b>	<b>17. INFORMANT</b> Address <b>Mrs Minnie William 31 W. Bethel Street.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241x</b> DUE TO <b>arterio sclerotic coronary heart disease</b> <span style="float:right">INTERVAL BETWEEN ONSET AND DEATH <b>10yrs</b></span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>bronchial asthma</b> <span style="float:right"><b>15 yrs</b></span> (c) _____						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <b>none</b> 19 <b>56</b>			<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>none</b>		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <b>Oct. 30</b> , 19 <b>56</b> , to <b>Oct. 12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 8</b> , 19 <b>56</b> , and that death occurred at <b>5:30P</b> M, from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i>			<b>ADDRESS</b> (Street, city or town, state) <b>115 N. Potomac Street</b>		<b>DATE SIGNED</b> <b>10-15-56</b>		
<b>PHYSICIAN'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b>			<b>Hagerstown, Maryland</b>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10-17-1956</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Hagerstown Maryland</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John R Watson Jr.</i>			<b>ADDRESS</b> <b>Hagerstown Md</b>		<b>24a. REC'D BY REGISTRAR</b> <b>Oct 16 1956</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <i>Shasth Bowers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 18 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 55 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1423 Virginia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Matilda Young				4. DATE OF DEATH Month Day Year October 15 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Thurmont Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Stull				14. MOTHER'S MAIDEN NAME Anna M. Ramsburg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Lula Itnyer Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) advanced generalized arteriosclerosis 9040 DUE TO Concussion and shock Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 1 hr 45min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and hit head while preparing to retire for the night					
20c. TIME OF INJURY Hour XXXX p. m. Oct. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-16-56	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR Oct. 20, 1956		24b. REGISTRAR'S SIGNATURE Blatt Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OCT 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10741

## CERTIFICATE OF DEATH

10768

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>81 Washington Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rex</b> Middle <b>Lynn</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-22-1909</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sheet metal worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchilds</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Newton J. Young</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Daley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-2483</b>		17. INFORMANT <b>Mrs. Imogene Young</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b> <b>545X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Saddle Thrombus iliac vessels</b> DUE TO (c) <b>thrombophlebitis left femoral artery (Post-op)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asystolic 6 days before demise</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>0. 01.</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>20 Sept 19 56</b> to <b>20 Oct 19 56</b> , that I last saw the deceased alive on <b>19 Oct 19 56</b> , and that death occurred at <b>3 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>135 N. Potomac St. Hagerstown, Maryland</b> DATE SIGNED <b>10/20/56</b>							
ACTUAL SIGNATURE <b>J. Wilson</b>				PHYSICIAN'S NAME (Type) <b>J. Wilson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Oct 25 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Powers</b>	



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OCT 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10745 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Wells 19769  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>48 Hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		d. STREET ADDRESS <u>301 Nt Valla Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NICOLA</u> Middle <u>---</u> Last <u>ZINGARELLI J</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb'y 13 1942</u>
9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>		IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>In School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nicola Zingarelli Sr</u>		14. MOTHER'S MAIDEN NAME <u>Rose Nese</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nicola Zingarelli Sr Hagerstown Md.</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound ( 12 gauge ) thru perineal</u> <u>9/19.8</u> DUE TO <u>body into abdomen ( hemorrhage &amp; shock )</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun discharged while sitting on a log attempting to light a cigarette</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00 p.m. Oct. 13 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In woods</u>		20f. (City or town) <u>Rural Boonsboro Wash Md</u> (County) <u>---</u> (State) <u>---</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 18 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown Wash. Co Md.</u> (State) <u>---</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wash H Bowers</u>	

BUREAU V. S.

OCT 22 1956

RECEIVED